EXHIBIT T

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

- -x

DISABILITY RIGHTS NEW JERSEY, INC., et al.,

Plaintiffs,

vs.

JENNIFER VELEZ, in her official capacity as Commissioner of the New Jersey Department of Human Services, et al.,

Defendants.

- -x

DEPOSITION OF KAREN PIREN

New Brunswick, New Jersey

Monday, January 30, 2012

REPORTED BY:

DANIELLE GRANT

REF #6789

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Q -- is that accurate? Okay.

And do you recall what -- what was said about whether or not these team meetings are taking place in the hospitals?

A Not specifically.

Q Okay. You also mentioned that one of the topics that you discussed with RENNIE advocates is that patients don't know about the RENNIE advocates. Do you recall that testimony?

A Yes.

Q Okay. What do you recall discussing about that topic?

A Whether or not patients know if there are RENNIE advocates in the state hospitals.

Q And what was said about that issue?

A That we are quite clear that patients all know that there are RENNIE advocates in the state hospitals.

Q And why are you clear that that's the case?

A Patients are hold, there are -- there's information plastered all over the hospital about RENNIE advocates.

Q What do you mean, there's information plastered all over the hospital?

A There are bulletins, bulletin boards, there are posters, there are phone numbers posted by telephones, patients are informed when they're admitted to the hospital about RENNIE advocates, patients are given booklets about their rights and with the RENNIE advocate phone number in it. There are many ways that patients are informed about the presence of RENNIE advocates in the hospitals. It's hard to believe that a patient wouldn't know there's a RENNIE advocate.

Q Okay. So I just -- you gave me a lot of information there and I'd like to just break it down. I think one of the ways that you said that patients are made -- made aware of RENNIE advocates is through signs in the hospital; is that correct?

A Um-hmm.

Q What are those signs?

A Bulletin boards, they're posted bulletin boards with RENNIE advocate information on them.

responsibilities?

A My job responsibilities were to assist the client service reps or RENNIE advocates in fulfilling their duties at RENNIE advocates in the state hospitals.

Q And how did you do that?

A Frequent visits, meetings.

Q What did you do when you would visit, do visits with the RENNIE advocates?

A We'd do charge reviews, see patients, review policies and procedures, work out whatever issues any hospital might be having.

Q Did you conduct trainings?

A We had one-on-one trainings all the time, um-hmm.

Q Like on-the-job trainings?

A Um-hmm.

Q Did you do any formal trainings with RENNIE advocates?

A Over the years, over the past ten years, sure, we've had formal trainings.

Q Which ones do you recall?

A Most recently, the last couple

trainings we did were more hospital wide trainings, but we have had meeting and monthly meetings and we have people come in if we need them. There hasn't been a lot of need for training because not much has changed in the past ten years and we don't have much of a change in the RENNIE advocates either. They generally are the same RENNIE advocates we've had for a long time.

Q Okay. So let's -- I just want to focus, though, on your role as the liaison to the RENNIE advocate. What years did you hold that title?

A It wasn't my title. My title was quality assurance specialist or something like that. And the role I had then was basically the same role I have now, as an advisor and a consultant to the RENNIE advocates in the state hospitals.

Q As a quality assurance specialist, is that the right title?

A Um-hmm.

Q Okay. As a quality assurance specialist you had responsibilities as being a

ensure the protection of patient rights, they respond to patient families when needed, but they certainly do not investigate complaints in the nature that I believe this is intended.

Q Do RENNIE advocates have any responsibilities regarding patient complaints?

A Yes.

Q What are those responsibilities?

A Well, the RENNIE advocate in regard to patients on refusing status, is that what you are referring to?

Q Sure, let's start there.

A Or are you referring to any kind of complaint?

Q Well, I'm referring to any kind of complaint, but if there is a line that needs to be drawn I'm trying to figure out what the RENNIE advocates do or don't do with regard to patient complaints.

A What the patient advocate has to do in regard -- if a patient calls the RENNIE advocate and says I'm getting medication and I don't want it, I don't want to take this medication. The RENNIE advocate job is to go to

the unit, speak with the patient and determine if any other action needs to be taken and to facilitate a process that ensures that the patient's rights are upheld in that regard. So that might mean that the RENNIE advocate would go to the psychiatrist, speak to the patient's doctor, explain the patient at all times. The RENNIE advocate would be responsible for explaining to the patient and helping the patient understand what his rights are in that regard.

Q Fair to say that the RENNIE advocates have responsibilities for patient complaints insofar as they relate to medication?

A The RENNIE advocates have the responsibility of ensuring that the patient's rights are upheld as regard to patient complaints. So that if a patient says I don't like the side affect I have of medication or I'm not, you know I'm getting too high a dose, the RENNIE advocate role is to go to the psychiatrist, go to the team, express -- assist the patient in expressing their complaints. And in all cases the RENNIE advocates do try to help

Q Do folks other than the client service reps attend?

A As needed, yes.

Q Okay. And who are some of the people who might go to those meetings?

A As I explained Dr. Eilers, the legal people, and if there's any other person we need we -- generally speaking those are the only people who attend.

Q Which legal people?

A Lisa Sciaston, Melanie Griffin, our legal people in central office.

Q How long do the meetings typically last?

A Three, four hours.

Q Are they held on a set day every month?

A Third Wednesday of every month.

Q What is the purpose of the meetings?

A The purpose of the meeting is to review any relevant information, to discuss any particular problems that any hospital or individual patient is brought up, and to

A Yes. And more importantly we're aware of -- yes. This can happen under certain circumstances though because a person can be put on CEPP and not be ready for discharge. They remain on CEPP and then decompensate and be actually committable again. We certainly try to avoid putting people who are ready for discharge on refusing status that would indicate that they're really not ready for discharge. But it can happen, it doesn't happen very often, but it does happen, it can happen. And we do take a look at that and we try to avoid that and educate teams about that as well.

Q Why is that something that you try to avoid?

A Again, if a person is ready for discharge they shouldn't be on refusing status. A person ready for discharge means that they are ready to go out and function and be in society and take their meds and do what they're suppose to do to stay well.

Q In that way are they similar to voluntary patients?

A No, not at all.

Q Okay, so but is it your understanding that voluntary patients cannot be subjected to the three-step process?

A Correct, unless it's an emergency.

Q And it's your understanding though that CEPP patients can be?

A Correct.

Q But that that depends on whether they're actually ready for discharge; is that right?

A No, that's not what I said.

Q Okay, so what did I get wrong?

A A person who is CEPP means that they are, technically a judge has declared -- it's still a legal status, a judge has declared that they're ready to be discharged or they are ready to begin discharge planning, more appropriately. But that doesn't necessarily mean that they're absolutely ready to be discharged at that immediate time and what can happen is that while a person is on this status, CEPP status, they become very ill again maybe because they didn't take their medication and it comes a time when the three-step process needs

speak to that. I don't really support a judicial process?

Q Why not?

A Because I don't think that a judge has any qualifications or -- I do believe somebody needs to be there to uphold the rights of the patient to make sure that the patient is -- is -- is being protected, that their rights are being protected, but I do also believe that the serious nature of the patients we have with mental illness and the very acute states that they -- they are in requires a psychiatrist or a psychiatric advanced practice nurse, since I am one, but requires that kind of clinical intervention and knowledge about a patient illness to make a really good informed decision.

Q Do you think that patients should have access to counsel?

A Of course, yes.

Q Do you think they should have a right to?

A Sure, they have a right to.

Q Do you think that lawyers should be

provided to patients when they're being restepped?

A I don't believe that's necessary, no.

Q Why?

A For the very reason I just gave you. Patients have access to lawyers in terms of they have, always have access to contact DRNJ. They have access to the public defender. They can hire their own attorneys, of course, but we do not provide -- we have hospital people who -- available from central office and for -- in the hospitals for court hearings and that kind of thing, lawyers are available to patients, but as relate to every three-step process, I don't feel that that would be efficient or a good use of time.

Q Is it your understanding that judges make decisions in civil commitment hearings?

A Yes.

Q Do you think that -- do you disagree with that process?

MR. LEYHANE: Objection.

on page, the page ending 800, one of the definitions of for less restrictive intervention. Do you see that?

A Yes.

Q Is that a term that you are familiar with or that's used in your job?

A Yes.

Q And what is your understanding of what that means?

A This, as we have progressed through the last number of years in mental health treatment we are changing our system from one of a kind of a paternalistic sort of treatment where, you know, a patient does what you say and that's it, to one of person centered, patient participate of treatment. In that regard, over the years we have moved towards less restrictive interventions overall, including medication, including seclusion, restraint, including the use of forced medication, including very prescriptive procedures to one where we hopefully are using less restrictive, more person centered treatments so the patient has a right to choose and talk about ahead of time

before an incident occurs what interventions might be helpful to him. And this is written in a treatment plan and that is what the teams are required to do before a person is, say for example, put in seclusion or put into restraints or given forceable emergency medication. So less restrictive interventions are generally those selected by the patient.

Q Okay. So fair to say there's a movement away from, or movement towards using less restrictive intervention when possible?

A Yes, in every hospital nationwide.

Q And have you heard from your RENNIE advocates or otherwise been made aware of situations where a patient requested a less restrictive intervention but was forcibly medicated instead?

A I haven't heard of any specifics in that regard.

Q Are you aware of that happening generally?

A I'm sure it can happen generally. I mean I'm sure that things like that happen.

Q If you wanted to know more about

whatever is necessary as far as what we already discussed. If the RENNIE advocate -- if the patient requires or asks that the RENNIE advocate go to the team meeting with the patient, the RENNIE advocate will do that. But the RENNIE advocate is not there really advocating for the patient's wishes, the RENNIE advocate is advocating and seeing to it that the process is followed, that the legal process is followed, that the patient's rights are -- the patient is given his due process, the patient is given his opportunity to speak to the treatment team, the patient is given the time to speak to the treatment team. The patient is explained -- the information is given to the patient about the process.

Q So turning back to page, the page ending 806, back on AB:504. If you look down, there's is a footnote here?

A Yes.

Q Sorry, one minute.

If you look at where it says 2A, "Although it is possible to devise a treatment plan that is available at the hospital and will

Q How often does that happen?

A It happens fairly often.

Q Once a month?

A I can't quantify it that way for five different hospitals, honestly I cannot. But it does happen and it happens fairly often and unfortunately we do not keep data on that which I have asked the RENNIE advocates to begin keeping that data because it does absolutely does happen.

Q Why is that a data point that you would be interested in tracking?

A Because you're asking me the question.

Q Is it fair to say because of the lawsuit?

A Absolutely, we never thought about keeping that information although we know that it does happen. We just never thought about keeping it.

Q As a matter of percentages could you say how often you think --

A I, honestly, it would be such a random guess it wouldn't be worthwhile for me to

make such an observation.

Q Do you know if the percentage -- strike that.

In the even that it's a delegate as opposed to the medical director who completes step three, does that affect how frequently they will agree or disagree with the treating psychiatrist recommendation?

A I couldn't say whether it does or doesn't. It's very rare that the procedure is delegated though very rare.

Q Fair enough.

A Yes.

Q Are you aware of any circumstances where a patient was involuntarily medicated after step two but without the medical director or his delegate reviewing the patient's record?

A I'm going to say again that I'm certain that can happen, and if it's brought to anyone's attention then steps are taken to rectify the situation.

Q Are you aware of any instances and actually you can turn back to page 807, and you see about middle of the page under step three

A Yes.

Q So you have the option of either a psychiatrist or an APN?

A We do.

Q Are there any other folks who do independent reviews?

A Not to my knowledge, well, I say that but anyone with a license actually I guess a psychologist could, technically but we are looking at medication issues so you want someone who's medication savvy.

Q When independent reviews do take place, what is involved in that process?

A What's generally involved is an orientation of the psychiatrist doing the independent review, the psychiatrist, generally we'll send them some of the pertinent data of the patient so they have an opportunity to review it prior to coming to the hospital. They come to the hospital, meet with the patient and the team if necessary, the medical director if necessary, whoever they feel is necessary and they make a determination, give us a written report and leave.

A Again, the issue was brought to the managing physician who brings it to the doctors and tells them what they have to do. It's brought to the physicians by the RENNIE advocate, brought to central office where it's addressed by the -- at managing physicians meetings by Dr. Eilers. So there are various different levels and then we continue to monitor the situation.

Q Okay. And do you know if this issue was raised in all five of the psychiatric hospitals to deal with the monthly progress notes?

A It has been raised at one time or another in all the hospitals, yes.

Q Were you part of that process in educating physicians about the issue?

A In the same way that I just referred to in that, for one thing we developed monthly progress note forms that have a particular space that refers to refusing status patients so that the doctors would remember to document and evaluate that process. That's a number of years ago.

EXHIBIT U

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

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DISABILITY RIGHTS NEW JERSEY, INC., et al.,

Plaintiffs,

vs.

JENNIFER VELEZ, in her official capacity as Commissioner of the New Jersey Department of Human Services, et al.,

Defendants.

- -x

DEPOSITION OF ANTHONY HAYNES

Hammonton, New Jersey

Tuesday, January 24, 2012

REPORTED BY:

DANIELLE GRANT

REF #6787

Q When did you start working at Ancora Psychiatric Hospital?

A It was January the 3rd, 1977.

Q What was your position at that time?

A Human service assistant.

Q What were your responsibilities in that job?

A Caring for the patient, bathing, feeding, taking care of the patient, personal need and supervision.

Q Before that job, did you have any experience in psychiatric hospitals?

A No, but I worked with at some point my life the Chatam County Association for Retarded Citizen. I can't remember, but that was my first exposure to the mental health field.

I believe I had at short stint in Savanna at the Georgia Regional Hospital, which is a psychiatric facility.

Q How long did you work as a human services assistant at Ancora?

A I really can't remember, sir. I

know it was --

Q Was it more than one year?

A For the assistant, let us say within a year, let's say a year.

Q How long have you been a RENNIE advocate at Ancora?

A About 14 years.

Q So it's 2012 now, so since approximately 1998, does that sound right?

A Yes.

Q Between 1977 when you started working at Ancora and 1998, what other positions did you hold?

A The first position is a human service assistant, and when the civil service presents the test, you take the test, you pass it, you become a human service technician.

Q And for how long did you have that role?

A Until I had the position as the patient advocate.

Q And when you say patient advocate, do you mean the RENNIE advocate?

A No, sir, I started out as the

Q So if a patient doesn't come to you with a complaint, do you ever inform them of their right to withhold consent to treatment?

A Well, the patients are advised of this upon admission and that they can always contact the RENNIE advocate. And if by chance they contact me, then I go back over those.

Q Who advises the patients upon admission?

A Well, the clinical staff, the admission staff. They are given booklets and documentation and this information is conspicuously posted throughout the institution.

Q How do patients who bring you complaints know that you work at the hospital?

MR. LEYHANE: I'm sorry, Anthony, wait a minute.

That he what does what? My fault, I lost the last part of the question.

(The requested portion of the record was read back.)

Q Do you need me to rephrase the question?

A No, because it's posted.

right?

A That's correct.

Q But the policy statement that's on the page, the first page, the first paragraph of this document JV49.

A Yes, sir.

Q It says that "The RENNIE advocate will be responsible for insuring that due process procedures are adhered to and patient's right of treatment refusal is protected."

Do you see that?

A That is correct.

Q How do you go about insuring that due process procedures are adhered to?

A Because they are the guidelines that states the procedures that have to be followed when medicating a patient against their will and is spelled out.

Q Let's go back to Plaintiff's Exhibit this is.

A 3, sir.

Q And this is the 2011 version of AB:504?

A Yes.

patient," do you see that?

A Um-hmm.

Q What is your understanding of why that sentence is in this document?

A Because of the fact that we're all trying to get the patient to understand what's going on in the process, and I need to hear from the patient. What is your objections, what are your concerns, what do you want to be able to say. And then once I have that information, at the meeting I can fully present the patient's side.

Q Have there been situations in the past in which the second step was not, scratch that.

Have there been situations in the past in which the second step has been initiated before you as the RENNIE advocate have had a chance to meet with the patient?

A Yes, I was notified at the end of the third step, my notification was at the end of the third step. But they have changed that now that I am to be notified really before the initiation of the first step.

Q Why is it important for you to meet with the patients before at least the initiation of the second step?

A So I can insure that the patient's story is told.

Q And how do you insure that?

A By speaking with the patient and attempting to negotiate with the physician. And if that's not good then to the treatment team, make my objection on to the treatment team and if there's not a positive resolution there, make it known to the medical director prior to him signing off on the third step.

Q Do you view your role as to advocate for the expressed preference of the patient?

A I do.

Q Do others on the staff of Ancora view your role that way?

A I can't speak for them I don't know.

MR. LEYHANE: Objection to the form of the question.

Q What is your understanding of how

A Oh, yeah, it went out to them.

Q Do you think the fact that a weekly meeting is required between the RENNIE advocate and the medical director, do you think that fact will have an influence on the medical director in terms of being more inclined to listen to the RENNIE advocate?

MR. LEYHANE: In terms of Ancora because that is what he has indicated.

A At my Ancora?

Q Yes.

A Well, we know it's there, and we know that it's our hospital but as I said, sir, I have no problem with my medical director. He maintains an open door for me, you know, I can -- I don't have to like schedule a meeting. I don't do that if I have a problem.

Q Now, the word designee appears in the sentence though I just read, which is the second paragraph on this page; is that right? It says, "The medical director or designee." Do you see that?

A Yeah.

Q Who might the designee be that you

patient interviewed regarding his or her medication or observed for extra pyramidal side effects?"

Do you see that?

A Right.

Q Is it your practice to interview patients who have been three stepped?

A Yes, sir.

Q How long do those interviews last?

A They can last from -- 504 required that I observe the patient.

Q For how long do you typically observe a patient who has been three stepped?

A It depends. It can be a glance at the patient.

Q How long is a glance?

A It can be just as I look at you and look back at the paper. I can engage the patient. It all depends on how the patient is presenting at the time.

Q Okay. In every instance in which a patient has been three stepped, do you ask the patient directly if they're experiencing side effects?

A If they will allow my approach. In the psychiatric business you learn when to approach a patient and when not to. They have a space and you've got to know when do you go into that space, and you'd best be invited. If not, you can be harmed.

Q Okay. Assuming that the patient is approachable, in those instances, do you make it a point to directly ask the patient whether they're experiencing side effects?

A Yes. I try to engage a conversation with the patient, not going directly to the medication. You know, what's going on? How you feeling? You know. What are they doing to you? You know. I see they put you on a refusing status, what's going on with that?

Q Okay. But at some point do you specifically address the question that is posed on the review form, whether they are experiencing extra pyramidal side effects?

A Well, that -- well, now -- yeah, when you read the bulletin, it's going to advise you that it's your job to observe the patient.

whether other components of the treatment plan is being implemented.

Q And do you have any understanding of why that does not happen?

A I don't know whether it happens or not. But I guess by this new thing that I'm supposed to meet with the medical director weekly, I guess I would be raising that question or ensuring that this is going on. I think that was another reason that was placed in there.

MR. REISMAN: Why don't we take a break and go off the record?

VIDEOGRAPHER: It's now 4:50. We're going off the record. This concludes Tape No. 4 of the videotaped deposition of Anthony Haynes.

(Whereupon, at 4:50 p.m., a recess was taken to 4:59 p.m.)

(The deposition resumed with all parties present.)

VIDEOGRAPHER: Now back on the video record. The time now is 4:59. This begins tape number five in the videotaped deposition of Mr. Anthony

EXHIBIT V

IN THE UNITED STATES DISTRICT COURT

DISTRICT OF NEW JERSEY

CIVIL ACTION NO. 10-3950-DRD

- - - - - - - - - - - - - - - -x

DISABILITY RIGHTS NEW JERSEY, INC., a New Jersey non-profit corporation,

Plaintiff

vs.

JENNIFER VELEZ, in her official capacity as Commissioner, State of New Jersey Department of Human Services, et al.,

Defendants

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VIDEOTAPED DEPOSITION OF JOHN LUCHKIW

New Brunswick, New Jersey

Thursday, March 15, 2012

REPORTED BY:

STEVEN R. MACK

REF #7003

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mental health clinics.

Q. What does the case manager do?

A. Basically social work without the clinical -- clinical aspect to it. So we'd find housing for people to ensure that they would keep their Section 8 housing, I would try to -- on a very shallow level do some maybe job coaching, things along those things, just to show that people were being able to survive in the community.

Q. And you stated that your current position is a client services representative at Greystone?

A. Yes. Yes.

Q. And when did you start as a client services representative?

A. It was in the summer of '99.

Q. And how were you hired for that position?

A. Through an interview process.

Q. Did you apply?

A. Yes, I did.

Q. How did you know that the position was available?

A. It was posted.

Q. And --

Q. Can you think of anything else besides psychopharmacology, psychotherapy, occupational therapy, music therapy, or art therapy?

A. Well, there's social services, there's whatever. Nursing, there are nursing programs.

Q. What do you mean by social services?

A. Social work. There could be like predischarge groups, things along those lines.

Q. And do all the patients at Greystone receive every type of treatment?

MR. CHABAREK: Objection to form.

A. No.

Q. Do you know how it's determined which modality will be used with the patient?

A. It's -- it's a combination between the treatment team and the patient's preferences also. So the patient has input.

Q. How does the patient make their preferences known?

A. Through dialogue.

Q. And when does the dialogue occur?

A. Usually during the treatment team meeting, or at any time.

Q. The patients don't always go to the treatment team meetings, correct?

Q. It was marked in the deposition of Anthony Haynes.
A. Um-hum.
Q. Do you recognize this?
A. Yes.
Q. And what is it?
A. It's the state civil service's job description for client services representative.
Q. And that's your position, correct?
A. Yes, it is.
Q. And do you want to take a look at it and confirm that it's complete?
A. To the best of my knowledge it is.
Q. It's dated 1993.
A. Um-hum.
Q. Do you see that? Has there been an updated job description?
A. Not that I'm aware of.
Q. Okay.
A. Um-hum.
Q. So the definition of your position it states is "Under general direction of a supervisory officer, promotes and initiates client advocacy, receives, investigates, and makes recommendations concerning client complaints and members of their

family to ensure the protection of client's rights -- client rights; does related work as required."

A. Um-hum.

Q. Is that correct?

A. Yes.

Q. That's an accurate description of your job?

A. According to this, yes.

Q. Well, do you agree with it?

A. Generally speaking, yes.

Q. Is there anything that you disagree with?

A. No.

Q. And then under examples of work, the first example is, "Screens all client complaints directed to his/her office, investigates the complaints, and recommends and/or takes necessary actions to resolve complaint to client satisfaction." Did I read that correctly?

A. Yes.

Q. Have you ever received complaints from patients or families regarding long-term medication?

A. Yes.

Q. How often does that happen?

A. Yes, I am.
Q. And would you agree that Rennie advocates specifically deal with medication issues?
A. Amongst other things they deal with medication issues.
Q. But not all client services representatives are Rennie advocates, correct?
A. Correct.
Q. But at Greystone both of you are?
A. Yes.
Q. Is there a specific job description for a Rennie advocate, a written one?
A. The only written reference I've ever seen to a Rennie advocate is in A.B. 5:04 where the hospital can appoint an appropriate, what they deem as an appropriate title to the position of Rennie advocate.
Q. Sometimes they're called patient advocates, too, correct?
A. In a generic way, yes.

MS. KOLOD: This should be 18.

(Plaintiff Exhibit No. 18 was marked for identification.)

MS. KOLOD: Okay. The plaintiff has -- the witness has just been handed a document

Q. -- that -- on Exhibit P-18 that periodic reminders at life -- oh, sorry. That there are grievance posters posted near public telephones; is that correct?

A. Um-hum.

(Plaintiff Exhibit No. 19 was marked for identification.)

MS. KOLOD: I'm handing the witness a document marked P-19, which is Bates-stamped JV000113.

BY MS. KOLOD:

Q. Is this a grievance poster?

A. It's an example of one.

Q. Are there other kinds of grievance posters?

A. Yeah. We have some with our names on them, we were asked to put some with our names on them, and we've complied with that.

Q. Are posters like this one, like Exhibit 19, still at the hospital?

A. Yes.

Q. But there are also posters with your names on them?

A. Yes, there are.

Q. With yours and Charles Petty?

A. Yes.
Q. Do they mention medication on them?
A. No, not necessarily.
Q. Do any of them do?
A. Not that I recall.
Q. And where are these posted specifically?
A. On the unit bulletin boards.
Q. Do all the units have bulletin boards?
A. Yes.
Q. And are there grievance posters on all the bulletin boards?
A. I'd like to think so, yes.
Q. Do you check?
A. Periodically.
Q. How often?
A. Usually whenever we go to a particular unit for a call.
Q. So how often does that happen?
A. Daily.
Q. Have you ever noticed that there wasn't a grievance poster?
A. Yes. And we've gotten complaints about there not being grievance posters, so we just print them up and put them up.
Q. How long does it take?

A. Five minutes.
Q. And that's your phone number on that poster, correct?
A. That is the patient hotline number, toll-free.
Q. So what happens when someone -- who answers when someone calls that number?
A. It is a voice mailbox to assure that it would be called, and then we will check the voice mailbox periodically to -- so we have a date, timestamp, everything, and then we're able to handle the call.
Q. How often do you check the voice mail?
A. At least daily, excluding weekends of course.
Q. Is there an average number of messages you get when you check it?
A. No. It fluctuates.
Q. Would you be surprised if there were 20 messages?
A. Very.
Q. Would you be surprised if there were -- there was only one?
A. No.
Q. So what about ten? Would that surprise

that's kept of --

A. Yes.

Q. -- these kinds of complaints?

MR. CHABAREK: Just let her finish the question.

A. Oh, I'm sorry. I'm sorry.

Q. Would you ever do an incident review form as a result of an involuntary medication complaint?

A. I could.

Q. Have you?

A. No.

Q. Do you know if Charles Petty ever has?

A. I don't know.

Q. Okay. Now I would like to go back to Px-1, the description of the client services representative job.

Okay. The second example of work is, "When requested, will assist professional staff by explaining to clients the nature of their treatment and the risks involved and informs them of their right to withhold consent to such treatment."

Did I read that correctly?

A. Yes.

Q. Do you perform this task as it relates

to involuntary medication?

A. Yes.

Q. How do you do that?

A. I will meet with the patient and explain to them the -- the A.B. 5:04 and how it can pertain to them.

Q. And what do you tell them about their right to withhold consent?

A. That although they do have a limited right to refuse their medication, the hospital has a co-related responsibility to treat them to the best of our ability, and that may fall under them getting medications, you know, involuntary -- involuntarily or potentially against their will.

Q. Okay. Now, skip the next three examples. The sixth one says, "Provides protection for the client from official error, abuse, or neglect and functions as a preventive influence by providing a means by which the patient can ventilate feelings."

A. Um-hum.

Q. Do you do that?

A. I'd like to think I do, yeah.

Q. We already talked about abuse and neglect. Is there any more, anything else that

A. Yeah.
Q. If you saw a three-step form -- you're familiar with three-step forms, correct?
A. Um-hum.
Q. Yes?
A. Yes. Sorry.
Q. That's okay. If you saw a three-step form where the justification for medication was the patient said he felt like he wanted to hit somebody, would that be appropriate?
MR. CHABAREK: Objection to form.
A. No.
Q. That's not good enough?
A. I don't think so, no.
Q. Okay. The next example of work is, "Visits resident area on a frequent basis and discusses complaints with clients and/or staff and attempts to resolve them by recommendations, negotiations, direct action, or appropriate referral."
Do you do this?
A. Yes.
Q. How frequently do you visit resident areas?
A. Daily.

spent related to your position on these committees?
A. Maybe 10 percent.
Q. Do you ever discuss involuntary medication in the Ethics Committee?
A. Not that I recall.
Q. What about the Patient Safety Committee?
A. The nur -- there is -- if there are medication issues, the nursing aspect of that committee brings them up.
Q. Okay. And on the Library and Research Committee, has anyone ever brought up that there should be law books in the patient library?
A. No.
Q. So you advocate for the patients; is that correct?
A. Yes.
Q. Do you consider yourself to be an independent hospital?
A. No.
Q. Why not?
A. In so many words that's who signs my check.
Q. How many patients are at Greystone? Do you know?
A. 475, 500. We've just had an influx, so

Q. Do you know how many patients are on refusing status now?
A. Offhand I would guess -- I would say about 55.
Q. But you would be able to confirm that number by checking your reports, correct?
A. (Witness nodding head)
Q. Yes?
A. Yes.
Q. And do you know how many functionally incompetent patients there are?
A. I do believe there's eight.
Q. Have you noticed any changes in the number of patients on refusing status lately, whether it's gone up or down?
A. It's gone up a bit.
Q. In what time frame?
A. Over the last couple of months.
Q. Do you know why?
A. No.
Q. Do you have any guesses?
MR. CHABAREK: Objection. You're not here -- you're not here to guess but ...
Q. Do you have any theories based on your professional knowledge?

yourself?
A. That we're the client services rep patient advocates. We won't necessarily say Rennie advocates.
Q. Do you think that the patients know what Rennie advocate means, that term?
MR. CHABAREK: Objection to form.
A. I offhand -- I don't know.
Q. Have you ever introduced yourself to a patient as a Rennie advocate to have them respond, What's that?
A. Yes.
Q. Yes. About how often does that happen?
A. I couldn't put a number to it.
Q. Because you don't know or because it's -- it happens a lot?
A. It happens frequently.
Q. Do you think the patients at Greystone are dangerous?
MR. CHABAREK: Objection to form.
You can answer.
A. Yeah, a lot of them are.
Q. Most of them?
MR. CHABAREK: Objection to form.
You can answer.

A. I think there's an unpredictability out of almost every one of them.
Q. Have you ever been attacked?
A. Yes.
Q. About how many times?
A. Probably half a dozen.
Q. So six times since 1994?
A. Or since '92.
Q. Ninety-two.
A. About six times, yes, since 1992. Well, without the '97 and '98 when I wasn't there.
Q. Got it. What was the most severe attack?
A. I was punched in the face.
Q. When did that happen?
A. Maybe five, six years ago.
Q. What were the circumstances surrounding that incident?
A. Basically nothing.
Q. Was the patient on medication?
A. I would think, yeah. Well, yes, they were on medication.
Q. Do you know what medications the patient was on?
A. No.

Q. The other approximate five times that you were attacked, do you know if those patients were medicated before they attacked you?
A. I couldn't say positively, but I mean -- I couldn't say positively.
Q. Did you ask afterwards?
A. No.
Q. Are you afraid of the patients at Greystone?
A. Some.
Q. What makes you afraid of the ones you're afraid of?
A. Again unpredictability.
Q. So how do you know who to be afraid of then?
A. I meet them.
Q. And so would it be the ones who -- whose behavior is generally less predictable, you're more afraid of them?
A. Yes.
Q. And have you ever seen patients attack anybody else?
A. Yes.
Q. About how often does that happen?
A. I couldn't put a number to that.

VIDEOGRAPHER: This marks the beginning of disk 2 in today's deposition of John Luchkiw. The time is 11:43 a.m., and we are on the record.

BY MS. KOLOD:

Q. I just want to remind you, Mr. Luchkiw, that you're still under oath --

A. Yes.

Q. -- and you will be for the entirety of the deposition?

A. Yes.

Q. I would like to turn back to Exhibit 18.

A. This? Okay.

Q. Yes. Which is the grievance policy, correct?

A. Yes.

Q. Turn to the page that's marked at the bottom JV016722.

MR. CHABAREK: You see it?

A. Yeah. This one. Okay.

Q. Do you recognize that?

A. Yes.

Q. And what is it?

A. The patient's bill of rights acknowledgment form.

Q. So patients sign this when they're admitted?

A. Yes.

Q. Okay. And the patients -- and that it shows that they have read and understood the patient bill of rights, if they sign it?

A. Yes.

Q. And the patient bill of rights is a document that starts on the next page, correct?

A. Yes.

Q. So who makes sure that the patients sign the acknowledgment?

A. That is done upon admissions.

Q. Are you involved in that process?

A. No.

Q. Do you know if they check to make sure the patients understand before signing?

A. I don't know. I'm not a part of that process.

Q. You don't know anything about it?

A. No. All I know is that it's given to them upon admission.

Q. Okay. Do you know what happens to this acknowledgment form once it's signed?

A. It's to be placed in the clinical

Q. Any setting. But yeah, a class or a training.

A. Nothing formal that I'm aware of.

Q. Is there any requirement that anybody go over the patient's bill of rights with the patients on a yearly basis just to make sure that they still understand?

MR. CHABAREK: Objection to form. You can answer.

A. Not that I'm aware of.

Q. Has the patient bill of rights changed at all since you started at Greystone?

A. The only one that I'm really aware of is changing NJP&A to DRNJ on it.

Q. And do you know if there was -- anything was done to alert the patients of the change, the patients who already -- who had already acknowledged the patient bill of rights?

A. No. But we -- when the name change was done it was -- it was noted through the DRNJ advocates, and if people asked us we would tell them that there was the name change.

Q. And am I correct that you testified that there are not trainings or classes held for patients on the patient's bill of rights?

Q. Okay.

MR. CHABAREK: Is that a yes?

THE WITNESS: Yes.

MR. CHABAREK: Okay.

Q. Okay. On No. 21, a conditional right again. "To petition a court to review whether you are being legally detained, parenthetical, file a writ of habeas corpus, or to enforce any other right through a civil action, whether stated in this notice or otherwise available by law."

Do you -- have you ever received any complaints related to the denial of that right?

A. Yes, but it was -- there's actually a recent one where the patient didn't realize that the fact of us having court on the premises is -- him appearing in that court is his habeas corpus.

He was expecting it to be immediate. As soon as he wrote the letter requesting it, he wanted to go in and see the judge right away. But we had to explain to him that the fact that when he goes in on his court date, that is his habeas corpus.

Q. And is that -- is that a review of the commitment decision or what -- what was the circumstances, why was there a habeas corpus

Q. Anybody else?
A. Not that I recall.
Q. Were there any handouts given?
A. The, the -- the changes, yeah, the -- there was the physical, you know, the bulletin I guess in and of itself, there was that and the new form that we were using.
Q. The new 72-hour form?
A. Yes.
Q. Was there a PowerPoint presentation, anything like that?
A. No.
Q. It was just Piren speaking?
A. Yes.
Q. Okay. Are there any regularly scheduled trainings that you have to attend?
A. Regularly scheduled trainings? No. Aside from your basic hospital trainings that are required by law.
Q. What are those?
A. So we have like there -- I don't know exactly what they all -- all of them, but we have what we call an Oktoberfest, training thing in October. Yeah. So, and all mandatory hospital trainings are done that year, all the ones that have

to be updated annually.

Q. And are they done on a hospital basis or does the central office conduct them?

A. This is hospital.

Q. But the 72-hour training was central office?

A. Yes.

Q. Yeah. Okay. Did you receive any training on the Rennie decision, the factual case, the court case?

A. The --

MR. CHABAREK: Objection to form. You can answer.

A. The original 5:04?

Q. Well, the -- the legal opinion that led to it --

A. Yes.

Q. -- that -- yes.

(Plaintiff Exhibit No. 20 was marked for identification.)

MS. KOLOD: I've handed the witness a document marked Exhibit 20, Plaintiff Exhibit 20, which is Bates-stamped JV000291 to 296.

BY MS. KOLOD:

Q. Have you seen this before?

A. Correct.
Q. It was Ancora?
A. I don't know where it happened.
Q. Okay. Let's turn to page 4 of the new policy, A.B. 5:04 --
A. Um-hum.
Q. -- which is Bates-stamped JV015802. And it says at the top "Patient Advocates." Does that also mean Rennie advocates?
A. Not necessarily.
Q. What else could it mean?
A. Well, it says each facility -- it could be -- Rennie advocate is a component of a patient advocate's office. It doesn't necessarily have to be. We have patient advocates who aren't Rennie advocates.
Q. Got it. It says, "Patient advocates working for the Department of Human Services shall be engaged in assisting patients with respect to medication issues."

Do you agree that that's part of your responsibilities?
A. Yes.
Q. Okay. As a Rennie advocate now how do you assist? I mean what do you do?

A. How would I assist in this process as with -- regarding medication issues?

Q. Yes.

A. Where a patient has a particular concern about their medication, will listen to, you know, what the concern is and potentially hope to address it in a satisfactory manner.

Q. Okay. Then turn to page 8. And page 8 starts "Patients who Refuse Psychotropic Medication," correct?

A. Yes.

Q. And then it goes through the first step. So the first step is the physician's meeting with the patient?

A. Yes.

Q. So you're aware of meetings between physicians and patients --

A. Yes.

Q. -- of the first step? Yes.

And do you know if doctors express concerns about medications to patients?

MR. CHABAREK: Objection to form. You can answer if you can.

A. Yeah.

Q. And they say things like this medication

A. Well, we review the -- we review the chart as soon as possible after receiving it, basically to see whether the complace -- the process has been complete. I don't know. I mean maybe I was speaking out of order as far as expressing the appropriateness of the treatment. I'm not -- I'm not really sure on that part of it.

Q. That sounds like something a doctor would do?

A. Yeah.

Q. Yeah.

A. That would be more -- what I would view more as the step 3.

Q. What the medical director does?

A. Yeah, as far as we're concerned at Greystone.

Q. Okay. When you do the review forms, do you check to make sure that the maximum doses on Exhibit 21 are not exceeded? We can go back and look at it. That's the training packet that --

A. Right, right, right, right. No, I got it. No, I know what that -- I know which one it is. Do I personally check that? No, not necessarily.

Q. Does anybody do you know?

A. I don't know offhand. I know as a part

of justification for medication if you are going above prescribed therapeutic levels, I do believe there has to be a review by the chief of psychiatry.

And we also have two independent pharmacies on the grounds of the hospital, so if there is something irregular, I'm sure that they would be able to catch it. We have a distribution pharmacy is one agency, and the second agency is a QA pharmacy; so it's like double and triple checking.

Q. I see.

A. So I would hope something like that would be caught.

Q. So they keep track of what's being prescribed to whom and at what levels?

A. Meaning who? The --

Q. The pharmacies.

A. Oh, yeah. They have to.

Q. Yeah. And so it would, you know, send up a red flag if the dose, the daily dose was double the maximum?

A. I would hope so. Unless there was, like I said, there was a review to determine that that was appropriate if something was outside of therapeutic range.

it.

Q. And yet you have no opinion as to whether it was medication-related?

A. I don't know. I don't know the facts in the case.

Q. And it's your understanding that patients refusing medication currently do not have a right to an independent judicial hearing prior to being medicated, correct?

A. In the state of New Jersey --

Q. In New Jersey.

A. -- yes.

Q. Have patients requested this?

A. I don't know. I don't recall anybody requesting that.

Q. Do you think -- and do you think this would improve the process for patients potentially subject to involuntary medication?

A. Improve the process?

Q. (Nodding head)

A. How -- I don't understand. How do you mean improve the process?

Q. Do you think there are problems with the three-step process?

MR. CHABAREK: Objection to form.

A. I think there's potentially problems with every process.
Q. So --
A. With -- with a judicial process it might potentially take a longer period of time.
Q. What would take a longer period of time?
A. Getting a judicial review.
Q. And do you think that that's a good thing or bad thing?
A. Potentially a bad thing.
Q. Is it possible that it could be a good thing?
MR. CHABAREK: Objection to form.
A. I mean I'm basing my -- my other answer on sort of conjecture, so I mean I guess you can say either side.
Q. But you said that you think every process has its problems, correct?
A. I think so.
Q. So what are the problems with the three-step process?
A. Globally --
Q. Anything.
A. -- the whole thing?
Okay. I think that you pointed

opinion of what could make either the three-step process -- well, I'll start with the three-step process. Has anyone ever asked your opinion on what can make the three-step process better, anyone with the power to change it?

A. I'm trying to think of a specifically. Because what -- I know there was a -- they were doing a rewrite of the administrative bulletin, and we were asked our opinions on different segments of it. I can't think of anything specifically about it because we were doing it over the course of time, but we were ask -- our opinions were asked of it.

Q. When was this?

A. It was like a couple of years period almost, like two-thous -- I think it might have started in 2004, 2005.

Q. Did the bulletin change as a result?

A. I don't recall. I don't think it did.

Q. Do you remember what you said when asked?

A. No, not -- not specifically. I just remember that we went through that process.

Q. Do you have any notes or anything related to that -- that process, those discussions?

A. I may.